FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007534

Facility Name: Rest Haven Central

Address: 13259 South Central Avenue (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 597-1000 **Fax #** (708) 389-9990

IDPA ID Number: 362382853002

Date of Initial License for Current Owners: 02/10/60

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (C) 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,638	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,327	7,759	10,553	31,639	8
9	SNF/PED					9
10	ICF	18,580	14,582		33,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,907	22,341	10,553	64,801	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.74%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/10/1960

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 95 and days of care provided 10,553

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	435,803	69,121		504,924		504,924		504,924			1
2	Food Purchase		388,417		388,417		388,417	(8,028)	380,389			2
3	Housekeeping	301,507	38,843		340,350		340,350		340,350			3
4	Laundry	79,562	30,567		110,129		110,129	(10,738)	99,391			4
5	Heat and Other Utilities			168,370	168,370		168,370	12,130	180,500			5
6	Maintenance	99,122		172,925	272,047		272,047	(28,601)	243,446			6
7	Other (specify):*											7
8	**TOTAL General Services**	915,994	526,948	341,295	1,784,237		1,784,237	(35,237)	1,749,000			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	3,961,582	443,097	421,754	4,826,433		4,826,433		4,826,433			10
10a	Therapy			758,791	758,791		758,791		758,791			10a
11	Activities	96,740	12,867	386	109,993		109,993		109,993			11
12	Social Services	146,216		2,850	149,066		149,066		149,066			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,204,538	455,964	1,198,781	5,859,283		5,859,283		5,859,283			16
	C. General Administration											
17	Administrative			867,000	867,000		867,000	(800,786)	66,214			17
18	Directors Fees											18
19	Professional Services			144,633	144,633		144,633	(58,402)	86,231			19
20	Dues, Fees, Subscriptions & Promotions			42,653	42,653		42,653	11,154	53,807			20
21	Clerical & General Office Expenses	310,411	39,331	109,343	459,085		459,085	444,388	903,473			21
22	Employee Benefits & Payroll Taxes			1,048,141	1,048,141		1,048,141		1,048,141			22
23	Inservice Training & Education			160	160		160	296	456			23
24	Travel and Seminar			5,068	5,068		5,068	19,435	24,503			24
25	Other Admin. Staff Transportation							2,034	2,034			25
26	Insurance-Prop.Liab.Malpractice			243,044	243,044		243,044	12,939	255,983			26
27	Other (specify):* Mgmt.Allc.of Benefits							114,328	114,328			27
28	**TOTAL General Administration**	310,411	39,331	2,460,042	2,809,784		2,809,784	(254,614)	2,555,170			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,430,943	1,022,243	4,000,118	10,453,304		10,453,304	(289,851)	10,163,453			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rest Haven Central #0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			515,252	515,252		515,252	(3,968)	511,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,860	174,860		174,860	(27,448)	147,412			32
33	Real Estate Taxes							8,818	8,818			33
34	Rent-Facility & Grounds							1,522	1,522			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			690,112	690,112		690,112	(21,076)	669,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		724,856		724,856		724,856		724,856			39
40	Barber and Beauty Shops		5,934		5,934		5,934	(5,934)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,536	106,536		106,536		106,536			42
43	Other (specify):* Nonallowable Costs			408,929	408,929		408,929	(408,929)				43
44	**TOTAL Special Cost Centers**		730,790	515,465	1,246,255		1,246,255	(414,863)	831,392			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,430,943	1,753,033	5,205,695	12,389,671		12,389,671	(725,790)	11,663,881			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,522)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,345)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,738)	4		8
9	Non-Straightline Depreciation	(99,698)	30		9
10	Interest and Other Investment Income	(68,553)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,250)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(70,151)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(200,004)	43		24
25	Fund Raising, Advertising and Promotional	(63,312)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,062)	43		28
29	Other-Attach Schedule See attached Schedule 5A	(160,108)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (721,743)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(4,047)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (4,047)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (725,790)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Central
Provider #: 0007534
01/01/04 to 12/31/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Schedule V Reference
Interehab Physiatry	(70,300)	43
Medicare Ancillary X-ray	(19,983)	43
Medicare Lab Ancillary	(21,230)	43
Disallow resident welfare	(10,788)	43
To offset beautician income with related expense	(5,934)	40
To offset other income with related expense	(31,873)	21
Total	(160,108)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian		Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
Convalescent Home	100	Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
		Rest Haven West	Downers Grove	Providence Mgmt. &		
				Development Co.	Tinley Park	Management Co.
				Providence Home		
				Health Care	Tinley Park	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 494	$ 494	1
2	V	5	Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	12,130	12,130	2
3	V	6	Maintenance	35,373	Rest Haven Illiana Christian Convalescent Home	100.00%	6,772	(28,601)	3
4	V	17	Administrative	867,000	Rest Haven Illiana Christian Convalescent Home	100.00%	66,214	(800,786)	4
5	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	11,749	11,749	5
6	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	11,261	11,261	6
7	V	21	Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	493,606	493,606	7
8	V	23	Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	296	296	8
9	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	19,328	19,328	9
10	V	25	Other admin. staff transport.		Rest Haven Illiana Christian Convalescent Home	100.00%	2,034	2,034	10
11	V	26	Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	12,939	12,939	11
12	V	27	Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	114,328	114,328	12
13	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	95,730	95,730	13
14	Total			$ 902,373			$ 846,881	$ * (55,492)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 41,105	$ 41,105	15
16	V	33	Real estate taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	8,818	8,818	16
17	V	34	Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	1,522	1,522	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 51,445	$ * 51,445	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		N/A - Voluntary Board with no compensation. See attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated cost	70,996,213	15	$ 3,030	$	11,580,506	$ 494	1
2	5	Utilities	Accumulated cost	70,996,213	15	74,367		11,580,506	12,130	2
3	6	Maintenance	Accumulated cost	70,996,213	15	41,515		11,580,506	6,772	3
4	19	Professional services	Accumulated cost	70,996,213	15	72,028		11,580,506	11,749	4
5	20	Dues, fees & subscriptions	Accumulated cost	70,996,213	15	69,035		11,580,506	11,261	5
6	21	Clerical & gen. office - salary	Accumulated cost	70,996,213	15	2,699,260	2,699,260	11,580,506	440,288	6
7	21	Clerical & gen. office	Accumulated cost	70,996,213	15	326,877		11,580,506	53,318	7
8	23	Inservice training & education	Accumulated cost	70,996,213	15	1,814		11,580,506	296	8
9	24	Travel & seminar	Accumulated cost	70,996,213	15	118,491		11,580,506	19,328	9
10	25	Other admin. staff transport.	Accumulated cost	70,996,213	15	12,467		11,580,506	2,034	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	70,996,213	15	79,324		11,580,506	12,939	11
12	27	Mgmt. allocation of benefits	Accumulated cost	70,996,213	15	700,904		11,580,506	114,328	12
13	30	Depreciation	Accumulated cost	70,996,213	15	586,888		11,580,506	95,730	13
14	32	Interest	Accumulated cost	70,996,213	15	252,004		11,580,506	41,105	14
15	33	Real estate taxes	Accumulated cost	70,996,213	15	54,062		11,580,506	8,818	15
16	34	Rent - facility & grounds	Accumulated cost	70,996,213	15	9,329		11,580,506	1,522	16
17										17
18	17	Administrative	Direct cost			720,689	720,689		66,214	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,822,084	$ 3,419,949		$ 898,326	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Mortgage & Additions	Varies	11/01/04	$ 4,800,000	$ 4,800,000	10/31/34	Variable	$ 40,696	1
2	Tax Exempt Bonds		X	Mortgage & Additions	Varies	2/26/97	2,900,000		2/26/27	0.0485	133,238	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,700,000	$ 4,800,000			$ 173,934	9
	B. Non-Facility Related*											
10								Bond Issuance Related Interest			926	10
11								Disallow non-care interest			(68,553)	11
12								Home office allocation			41,105	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,522)	14
15	TOTALS (line 9+line14)						$ 7,700,000	$ 4,800,000			$ 147,412	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Allocated from Home Office	8,818	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

Real estate taxes are allocated from a for-profit management entity.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven Central COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007534

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 342-8100 FAX #: (708) 348-8006

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-01-203-003-0000	New Home Office Building	$ 54,062.00	$ 8,818.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,062.00	$ 8,818.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	441,662	1960	$ 30,000	1
2					2
3	TOTALS	441,662		$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50			1960	$ 341,041	$	40	$	$	$ 341,041	4
5	50			1962	122,119		40			122,119	5
6				1963	86,546		40			86,546	6
7	93			1967	585,862	14,647	40	14,647		556,586	7
8				1975	147,301	3,683	40	3,683		110,469	8
	Improvement Type**										
9	Improvements			1967	312,475	7,812	40	7,812		293,962	9
10	Improvements			1970	74,824	1,871	40	1,871		65,485	10
11	Improvements			1971	10,740	269	40	269		9,146	11
12	Improvements			1972	3,992	100	40	100		3,300	12
13	Improvements			1973	2,002	50	40	50		1,567	13
14	Improvements			1974	1,001	25	40	25		755	14
15	Improvements			1976	8,418	210	40	210		5,980	15
16	Improvements			1977	1,073	27	40	27		738	16
17	Improvements			1979	450	11	40	11		286	17
18	Improvements			1980	629	16	40	16		400	18
19	Improvements			1982	3,077	77	40	77		1,771	19
20	Improvements			1983	4,063	102	40	102		2,244	20
21	Improvements			1984	11,366	284	40	284		5,964	21
22	Improvements			1985	5,552	139	40	139		2,780	22
23	Improvements			1986	308,545	7,714	40	7,714		146,566	23
24	Improvements			1987	242,285	6,057	40	6,057		109,026	24
25	Improvements			1988	144,720	3,618	40	3,618		50,174	25
26	Improvements			1989	75,090	1,877	40	1,877		30,023	26
27	Improvements			1990	258,016	6,450	40	6,450		100,130	27
28	Improvements			1991	88,476	2,212	40	2,212		32,700	28
29	Improvements			1992	51,572	1,289	40	1,289		16,757	29
30	Improvements			1993	283,946	7,099	40	7,099		85,777	30
31	Improvements			1994	396,618	9,915	40	9,915		110,079	31
32	Improvements			1995	207,113	5,526	40	5,526		51,766	32
33	Improvements			1995	13,913	928	15	928		8,816	33
34	Parking Lot Expansion			1996	74,714	1,868	40	1,868		15,878	34
35	Wing C & D Renovations			1996	226,501	5,662	40	5,662		48,127	35
36				1996	279,308	6,982	40	6,982		59,347	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting for Renovation	1996	$ 4,642	$ 310	15	$ 310	$	$ 2,635	37
38	Unit I A & B remodel:Carpty,& finishing	1996	49,263	1,232	40	1,232		10,472	38
39	Carpeting	1996	13,512	338	40	338		2,873	39
40	Unit I A & B remodel:Carpty, plmg, fire	1996	4,704	314	15	314		2,669	40
41	Unit II Patio /Alzheimer's Garden	1996	11,914	794	15	794		6,749	41
42	Hot Water Heater	1996	656	44	15	44		374	42
43	Roof	1996	22,981	574	40	574		4,879	43
44	A/C Circulator	1997	5,984	398	15	398		2,985	44
45	Chimney Vent	1997	236,778	9,472	25	9,472		71,041	45
46	Fascia	1997	211,804	8,472	25	8,472		63,540	46
47	Smoke Detectors	1997	3,264	130	25	130		975	47
48	Speed Bumps for Parking Lot	1997	3,910	156	25	156		1,170	48
49	Heating & Cooling System	1997	1,595	64	25	64		480	49
50	Nurses' Alarm System	1997	729	30	25	30		225	50
51	Piping	1997	8,750	350	25	350		2,625	51
52	Patio	1997	32,456	1,298	25	1,298		9,735	52
53	Carpeting	1997	3,975	159	25	159		1,193	53
54	Electrical Generator	1997	1,396	56	25	56		420	54
55	Wall Firestopping	1997	1,833	74	25	74		555	55
56	Interior design fee	1997	12,166	486	25	486		3,645	56
57	Electrical	1997	20,773	830	25	830		6,225	57
58	Wall Firestopping	1997	78,500	3,140	25	3,140		23,550	58
59	Switchboard	1997	2,331	94	25	94		705	59
60	Landscaping	1997	3,458	138	25	138		1,035	60
61	Parking Lot	1998	18,389	736	25	736		14,694	61
62	Air Conditioners	1998	2,002	80	25	80		520	62
63	Boiler Repairs	1998	8,807	352	25	352		2,288	63
64	Landscaping	1998	83,634	3,345	25	3,345		21,743	64
65	Patio Shelter	1998	19,906	796	25	796		5,174	65
66	Garden	1998	10,676	427	25	427		2,776	66
67	Benches	1998	706	28	25	28		182	67
68	Lobby remodel	1998	2,314	93	25	93		604	68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,257,156	$ 131,330		$ 131,330	$	$ 2,745,041	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,257,156	$ 131,330		$ 131,330	$	$ 2,745,041	1
2	Painting for Renovation	1998	3,873	154	25	154		1,001	2
3	Unit I A & B remodel:Carpty,& finishing	1998	20,171	806	25	806		5,239	3
4	Carpeting	1998	13,997		5			13,997	4
5	Unit I A & B remodel:Carpty, plmg, fire	1998	8,026	322	25	322		2,093	5
6	Unit II Patio /Alzheimer's Garden	1998	49,519	1,980	25	1,980		12,870	6
7	Hot Water Heater	1998	831	56	15	56		364	7
8	Roof	1998	991	100	10	100		650	8
9	A/C Circulator	1998	1,115	74	15	74		481	9
10	Chimney Vent	1998	519	20	25	20		130	10
11	Fascia	1998	789	32	25	32		208	11
12	Smoke Detectors	1998	1,081	72	15	72		468	12
13	Speed Bumps for Parking Lot	1998	781		5			781	13
14	Heating & Cooling System	1998	34,826	1,394	25	1,394		9,061	14
15	Nurses' Alarm System	1998	13,917	556	25	556		3,614	15
16	Piping	1998	682	28	25	28		182	16
17	Patio	1999	10,472	262	40	262		1,441	17
18	Carpeting	1999	6,283	628	10	628		3,454	18
19	Electrical Generator	1999	66,394	6,640	10	6,640		36,520	19
20	Wall Firestopping	1999	15,000	1,500	10	1,500		8,250	20
21	Interior design fee	1999	228	22	10	22		121	21
22	Electrical	1999	4,383	438	10	438		2,409	22
23	Wall Firestopping	1999	35,000	3,500	10	3,500		19,250	23
24	Switchboard	1999	5,696	570	10	570		3,135	24
25	Landscaping	1999	48,376	1,210	10	1,210		6,655	25
26	Parking Lot	1999	8,610	216	40	216		1,188	26
27	Air Conditioners	1999	80,030	8,004	40	8,004		44,022	27
28	Boiler Repairs	1999	9,060		10	906	906	4,984	28
29	Landscaping	2000	10,704	712	15	712		3,204	29
30	Patio Shelter	2000	5,150	256	20	256		1,152	30
31	Garden	2000	7,768	516	15	516		2,322	31
32	Benches	2000	958	94	10	94		423	32
33	Lobby remodel	2000	102,660	10,266	10	10,266		46,197	33
34	TOTAL (lines 1 thru 33)		$ 5,825,046	$ 171,758		$ 172,664	$ 906	$ 2,980,907	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,825,046	$ 171,758		$ 172,664	$ 906	$ 2,980,907	1
2	Dining Room Renovation	2000	6,269	416	15	416		1,872	2
3	Wing Renovation	2000	102,095	2,552	40	2,552		11,484	3
4	Boiler and Pump	2000	10,450	696	15	696		3,132	4
5	Ansul	2000	3,728	248	15	248		1,116	5
6	Generator	2000	8,629	430	20	430		1,935	6
7	Fire Alarm System	2000	10,135	252	40	252		1,134	7
8	Exhaust Fan	2000	2,780	184	15	184		828	8
9	Landscaping	2001	5,680	1,136	5	1,136		3,976	9
10	Lobby remodel	2001	41,806	1,045	40	1,045		3,658	10
11	A-Wing remodel	2001	51,393	1,285	40	1,285		4,498	11
12	Sinks	2001	5,165	344	15	344		1,204	12
13	Doors	2001	5,278	352	15	352		1,232	13
14	Ejector Pump	2001	9,674	645	15	645		2,258	14
15	Automatic door	2001	4,817	688	7	688		2,408	15
16	Dining Room Renovation	2001	3,076	439	7	439		1,537	16
17	Exam Room Decoration	2001	14,068	2,010	7	2,010		7,035	17
18	Sewage Pump	2002	718	48	15	48		120	18
19	Whirlpool renovation	2002	2,177	145	15	145		363	19
20	Roof renovation	2002	90,250	9,025	10	9,025		22,563	20
21	Code Alert	2002	3,164	316	10	316		790	21
22	Firestopping work	2002	3,108	78	40	78		195	22
23	Dining Room Renovation	2002	135,527	3,388	40	3,388		8,470	23
24	Cabinets	2002	4,928	704	7	704		1,760	24
25	Blinds	2002	1,045	149	7	149		373	25
26	File cabinets	2002	2,327	332	7	332		830	26
27	Furniture	2002	1,814	259	7	259		648	27
28	Dining Room Renovation	2003	17,358	2,480	7	2,480		3,585	28
29	Lights	2003	20,442	1,022	20	1,022		1,533	29
30	Roof renovation	2003	152,000	15,200	10	15,200		22,800	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,544,947	$ 217,626		$ 218,532	$ 906	$ 3,094,244	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,544,947	$ 217,626		$ 218,532	$ 906	$ 3,094,244	1
2	Menu boards	2003	2,160	216	10	216		324	2
3	Carpeting	2003	5,957	851	7	851		1,277	3
4	Sliding doors	2003	2,100	210	10	210		315	4
5	Wander system	2003	21,630	1,082	20	1,082		2,133	5
6									6
7	Tile	2004	24,492	1,225	10	1,225		1,225	7
8	Door	2004	4,579	229	10	229		229	8
9	Basement restroom	2004	37,076	1,854	40	1,854		1,854	9
10	Lights/shades	2004	3,562	356	20	356		356	10
11	Awning	2004	10,790	540	10	540		540	11
12	Shades	2004	1,960	140	7	140		140	12
13	Exit ramps	2004	5,450	182	15	182		182	13
14									14
15									15
16									16
17	Allocated from home office	2004	678,140			16,941	16,941	44,185	17
18	Book depreciation for assets not allowable for Medicaid			102,988			(102,988)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,342,843	$ 327,499		$ 242,358	$ (85,141)	$ 3,147,004	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,549,785	$ 184,592	$ 186,976	$ 2,384	Various	$ 1,058,099	71
72	Current Year Purchases	63,216	3,161	3,161		5-15 years	3,161	72
73	Fully Depreciated Assets	2,498,083					2,498,083	73
74	Allocated from Home Office	589,784		76,734	76,734		311,000	74
75	TOTALS	$ 4,700,868	$ 187,753	$ 266,871	$ 79,118		$ 3,870,343	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Home Office			$ 27,588	$	$ 2,055	$ 2,055		$ 5,759	76
77										77
78										78
79										79
80	TOTALS			$ 27,588	$	$ 2,055	$ 2,055		$ 5,759	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,101,299	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 515,252	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 511,284	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,968)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,023,106	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home office allocation				1,522			6
7	TOTAL				$ 1,522 **			7

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ N/A
13.	/2006	$ N/A
14.	/2007	$ N/A

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C8	hrs	$	5,086	$ 346,934	$	5,086	$ 346,934	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		1,050	100,125		1,050	100,125	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		4,115	311,732		4,115	311,732	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				724,856		724,856	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	10,251	$ 758,791	$ 724,856	10,251	$ 1,483,647	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,364	$ 10,364	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 520,008)	2,834,830	2,834,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	37,804	37,804	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,882,998	$ 2,882,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	30,000	13
14	Buildings, at Historical Cost	6,666,436	7,342,843	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,204,064	4,728,456	16
17	Accumulated Depreciation (book methods)	(7,994,290)	(7,023,106)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): BCBS Excess Liability	15,888	15,888	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,922,098	$ 5,094,081	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,805,096	$ 7,977,079	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 883,859	$ 883,859	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	211	211	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,076	164,076	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,885	50,885	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	9,459,449	4,659,449	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,558,480	$ 5,758,480	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		4,800,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,800,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,558,480	$ 10,558,480	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,753,384)	$ (2,581,401)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,805,096	$ 7,977,079	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,079,177)	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(241,137)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,320,314)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(433,070)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (433,070)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,753,384)	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,120,272	1
2	Discounts and Allowances for all Levels	(6,346,271)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,774,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,889,564	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,889,564	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	28,845	13
14	Non-Patient Meals	8,522	14
15	Telephone, Television and Radio	17,345	15
16	Rental of Facility Space		16
17	Sale of Drugs	824,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	68,719	19
20	Radiology and X-Ray	32,357	20
21	Other Medical Services	292,821	21
22	Laundry	10,738	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,284,074	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Assessment Fees	5,100	28
28a	Miscellaneous Income	3,862	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,962	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,956,601	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,784,237	31
32	Health Care	5,859,283	32
33	General Administration	2,809,784	33
	B. Capital Expense		
34	Ownership	690,112	34
	C. Ancillary Expense		
35	Special Cost Centers	1,139,719	35
36	Provider Participation Fee	106,536	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,389,671	40
41	**Income before Income Taxes (line 30 minus line 40)****	(433,070)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (433,070)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	1,928	$ 53,172	$ 27.58	1
2	Assistant Director of Nursing	1,968	2,011	44,590	22.17	2
3	Registered Nurses	39,912	42,055	1,118,005	26.58	3
4	Licensed Practical Nurses	26,984	29,018	630,881	21.74	4
5	Nurse Aides & Orderlies	157,049	169,326	2,071,601	12.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,080	30,649	14.74	9
10	Activity Assistants	6,578	6,825	66,091	9.68	10
11	Social Service Workers	9,852	10,360	146,216	14.11	11
12	Dietician	1,986	2,114	45,873	21.70	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,948	35,633	389,930	10.94	15
16	Dishwashers					16
17	Maintenance Workers	6,153	6,275	99,122	15.80	17
18	Housekeepers	25,335	27,144	301,507	11.11	18
19	Laundry	6,564	6,999	79,562	11.37	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,944	16,740	310,411	18.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,777	3,079	43,333	14.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	338,978	361,587	$ 5,430,943 *	$ 15.02	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	15,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,864	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	386	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Chapel Ministry	Monthly	2,850	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	8	$ 21,100		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,376	$ 286,029	L10, C3	50
51	Licensed Practical Nurses	3,497	131,333	L10, C3	51
52	Nurse Aides	78	1,528	L10, C3	52
53	TOTAL (lines 50 - 52)	8,951	$ 418,890		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Witt	Administrator	0	$ 66,214
Amount paid out of Home Office allocated in Col. 7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,214

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 867,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 867,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG Peat Marwick LLP	Accounting	$ 4,400
Altschuler Melvoin & Glasser LLP	Accounting	9,127
Laner, Muchin, Dombrow, Becker		
Levin, Tominberg, Ltd.	Legal	23,072
Myers, Miller & Krauskopf	Legal	96,432
July Diamond Associates, Inc.	Legal	254
Jackson/Lewis Attorneys at Law	Legal	11,348
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 144,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,730
Unemployment Compensation Insurance	71,299
FICA Taxes	400,050
Employee Health Insurance	3,891
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Education	2,117
Employee Medical	6,038
Drug Testing	4,640
Uniforms	
TDA Expense	67,811
Employee Welfare	380,565
Home Office Allocation	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,048,141

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,709
Advertising: Employee Recruitment	2,808
Health Care Worker Background Check	
(Indicate # of checks performed 80)	680
Life Services Network of Illinois	16,147
Miscellaneous Dues & Licenses	1,401
Miscellaneous Subscriptions	4,640
JCAHO	15,841
Home Office Allocation	10,581
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,807

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,276
Seminar Expense	3,899
Home Office Allocation	19,328
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,503

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven Central
Provider #: 0007534
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	144,633
Myers, Miller & Krauskopf:	
Disallowable legal settlement	(70,000)
Out-of-period legal fee	(231)
Medicaid legal fee accrual	533
LMDBLT:	
Reclassed from Professional fees	779
Michael Best & Friedrick LLP:	
Reclassed from Professional fees	336
Professional fees:	
Reclassed to Legal	(1,115)
Reclassed - collection fees	(453)
Allocated from Management Company:	
Legal	1,591
Other	10,158
Total (agree to Schedule V, line 19, column 8)	86,231

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8	N/A												
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven Central # 0007534 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSNI: $16,147**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **143,756** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **106,536**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,522**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG-Peat Marwick LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Rest Haven Illiana Christian
Provider #: 0007534
12/31/04

Allocated from Home Office:

Other Administrative Transportation	**$**	**2,034**

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	435,803	69,121	0	504,924	0	504,924	0	504,924
2. Food Purchase	0	388,417	0	388,417	0	388,417	-8,028	380,389
3. Housekeeping	301,507	38,843	0	340,350	0	340,350	0	340,350
4. Laundry	79,562	30,567	0	110,129	0	110,129	-10,738	99,391
5. Heat and Other Utilities	0	0	168,370	168,370	0	168,370	12,130	180,500
6. Maintenance	99,122	0	172,925	272,047	0	272,047	-28,601	243,446
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	915,994	526,948	341,295	1,784,237	0	1,784,237	-35,237	1,749,000
9. Medical Director	0	0	15,000	15,000	0	15,000	0	15,000
10. Nursing & Medical Records	3,961,582	443,097	421,754	4,826,433	0	4,826,433	0	4,826,433
10a. Therapy	0	0	758,791	758,791	0	758,791	0	758,791
11. Activities	96,740	12,867	386	109,993	0	109,993	0	109,993
12. Social Services	146,216	0	2,850	149,066	0	149,066	0	149,066
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,204,538	455,964	1,198,781	5,859,283	0	5,859,283	0	5,859,283
17. Administrative	0	0	867,000	867,000	0	867,000	-800,786	66,214
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	144,633	144,633	0	144,633	-58,402	86,231
20. Fees, Subscriptions & Promotion	0	0	42,653	42,653	0	42,653	11,154	53,807
21. Clerical & General Office	310,411	39,331	109,343	459,085	0	459,085	444,388	903,473
22. Employee Benefits & Payroll	0	0	1,048,141	1,048,141	0	1,048,141	0	1,048,141
23. Inservice Training & Education	0	0	160	160	0	160	296	456
24. Travel and Seminar	0	0	5,068	5,068	0	5,068	19,435	24,503
25. Other Admin. Staff Trans	0	0	0	0	0	0	2,034	2,034
26. Insurance-Prop.Liab.Malpractice	0	0	243,044	243,044	0	243,044	12,939	255,983
27. Other (specify)*	0	0	0	0	0	0	114,328	114,328
28. Total General Adminis	310,411	39,331	2,460,042	2,809,784	0	2,809,784	-254,614	2,555,170
29. Total General Administrative	5,430,943	1,022,243	4,000,118	10,453,304	0	10,453,304	-289,851	10,163,453
30. Depreciation	0	0	515,252	515,252	0	515,252	-3,968	511,284
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	174,860	174,860	0	174,860	-27,448	147,412
33. Real Estate	0	0	0	0	0	0	8,818	8,818
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,522	1,522
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	690,112	690,112	0	690,112	-21,076	669,036
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	724,856	0	724,856	0	724,856	0	724,856
40. Barber and Beauty Shop	0	5,934	0	5,934	0	5,934	-5,934	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	106,536	106,536	0	106,536	0	106,536
43. Other (specify):*	0	0	408,929	408,929	0	408,929	-408,929	0
44. Total Special Cost Ce	0	730,790	515,465	1,246,255	0	1,246,255	-414,863	831,392
45. Grand Total	5,430,943	1,753,033	5,205,695	12,389,671	0	12,389,671	-725,790	11,663,881

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	10,364	10,364
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,834,830	2,834,830
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	37,804	37,804
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,882,998	2,882,998
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	30,000	30,000
14. Buildings, at Historical Cost	6,666,436	7,342,843
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	4,204,064	4,728,456
17. Accumulated Depreciation (book methods)	-7,994,290	-7,023,106
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	15,888	15,888
24. Total Long-Term Assets	2,922,098	5,094,081
25. Total Assets	5,805,096	7,977,079
CURRENT LIABILITIES		
26. Accounts Payable	883,859	883,859
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	211	211
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	164,076	164,076
31. Accrued Taxes Payable	50,885	50,885
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	9,459,449	4,659,449
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	########	5,758,480
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	4,800,000
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,800,000
46.Total Liabilities	########	10,558,480
47.Total Equity	-4,753,384	-2,581,401
48.Total Liabilities and Equity	5,805,096	7,977,079

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	13,120,272
2. Discounts and Allowances for all Levels	-6,346,271
Subtotal - Inpatient Care	6,774,001
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	3,889,564
7. Oxygen	0
Subtotal - Anciliary Revenue	3,889,564
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	28,845
14. Non-Patient Meals	8,522
15. Telephone, Television, and Radio	17,345
16. Rental of Facility Space	0
17. Sale of Drugs	824,727
18. Sale of Supplies to Non-Patients	0
19. Laboratory	68,719
20. Radiologyand X-Ray	32,357
21. Other Medical Services	292,821
22. Laundry	10,738
Subtotal - Other Operating Revenue	1,284,074
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	8,962
28. Other Revenue (specify):	0
Subtotal - Other Revenue	8,962
30. Total Revenue	11,956,601
31. General Services	1,784,237
32. Health Care	5,859,283
33. General Administration	2,809,784
34. Ownership	690,112
35. Special Cost Centers	1,139,719
35. Provider Participation Fee	106,536
37. Other	0
40. Total Expenses	12,389,671
41. Income Before Income Taxes	-433,070
42. Income Taxes	0
43. Net Income or Loss for the Year	-433,070

Page